STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G002	A. BUILDING _____ B. WING _____	R 03/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N C C	6200 2ND STREET, NW WASHINGTON, DC 20011

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{W 000}	INITIAL COMMENTS Surveyor: 12301 A revisit survey was conducted from March 20, 2007 through March 21, 2007. A sampling of eight clients was selected from a population of twenty-nine (29) clients with various disabilities. The findings were based on observations, interviews with clients, family members, facility staff, school and day program staff, as well as the review of client habilitation and administrative records, including incident reports. The results of the follow-up survey revealed the facility had continuing deficiencies was not in compliance with the Condition of Client Protections.	{W 000}		
{W 104}	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Surveyor: 12301 Based on observation, interview and record review, the facility's governing body failed to provide general operating direction over the facility as evidenced below: 1. A follow-up survey was conducted at the facility on March 20, 2007 through March 21, 2007. Interview with Residential Program Director and the review of unusual incidents and investigative reports during the survey revealed the facility failed to document the results of investigation of the the following incidents:	{W 104}	The agency's policy has been revised These incidents were addressed as programmatic issues and not as instances that required "investigations". Two were behavioral concerns and addressed as such and the other was reiteration of supervision, and the observation of identifying environmental corrections that are potentially dangerous.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cordus N. Harper Jr. TITLE: Program Manager (X6) DATE: 4/27/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 104}	Continued From page 1 a. Client #3 injury which was caused when she was head-butted by Client #7 (February 16, 2007) b. Client #3 fall which resulted in a physical injury (February 17, 2007) c. Client #7's physical aggression which resulted in an injury to Client #9.(February 28, 2007) 2. Observation of the door and the window in the Rainbow apartment on March 21, 2007 revealed the frames continued to be taped to the edges of the door and window as they were observed by the surveyors to be on February 9, 2007. There was no evidence however that a more permanent solution to prevent the air from coming entering and escaping from the building had been implemented.	{W 104}	(a) See response to W154 (b) See response to W154 (c) No injury was noted for client # 9 2. The facilities department began working on a permanent solution for the air escaping on April 9, 2007 and anticipated date of completion on:	4/28/07
{W 120}	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Surveyor: 12301 Based on interview and record review, the facility failed to ensure that one of eight clients in the sample (Client #7) were provided outside services in accordance with their needs. The finding includes: Review of the Plan of Correction (POC) on March 20, 2007 at approximately 11:00AM revealed that Client #7 was to have an occupational therapy(OT) assessment to determine her ability to use a fork or knife during mealtime. Further	{W 120}	On March 20, 2007 the Occupational Therapist was scheduled to assess client # 7 at dinner time. However, on that day client #7 ate earlier than scheduled because staff was trying to ensure she would do an activity that was scheduled for the youth and forgot about the scheduled appointment with Occupational Therapist. The O.T. rescheduled the evaluation and the observation was done on:	3/21/07

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{W 120}	Continued From page 2 review revealed that the OT assessment would be conducted by March 21, 2007. Interview with the Assistant Program Manager on March 21, 2007 at approximately 4:25PM revealed that Client #7's OT assessment had to be rescheduled for a later date. There was no evidence that an OT assessment had been completed for Client #7.	{W 120}	The assessment was completed by:	4/9/07
{W 122}	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Surveyor: 12301 Based on observation, interview, and record review the facility failed to ensure each clients clothing was the appropriate size (See W137); failed to establish and/or implement policies that ensure the maintenance of each client's health and safety (See W149); failed to notify the designated administrator and other officials were immediately informed of allegations of abuse (See W153); failed to thoroughly investigate incidents of abuse (See W154); and failed to report the results of the investigation within five working days (See W156). The effects of these systemic practices results in the failure of the facility to protect its clients and to ensure their general safety and well being.	{W 122}	See responses to W137; W149; W153; W154; W156	
{W 137}	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients	{W 137}		

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{W 137}	Continued From page 3 have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Surveyor: 12301 Based on observation and interview, the facility failed to ensure each clients clothing was the appropriate size, for one of the eight clients (Client # 4) included in the sample. The finding includes: Observation of Client #4 on March 21, 2007 at 4:35 PM revealed him wearing well fitting clothing. Interview with the direct care staff supervising the client indicated the pants the client was wearing were a size 34. Inspection of the client's clothing supply at 2:37 PM revealed that several of the pants stored in the resident's drawer were of a larger size (I pair size 38, 1 pair size 40 and 1 pair size 44). Interview with the Qualified Mental Retardation Professional on March 20, 2007 and the record review on March 20, 2007 revealed a clothing inventory had been completed for the resident however the clothing had not yet been purchased. There was no evidence there was no evidence the client's right to retain and adequate supply of appropriately sized clothing was exercised.	{W 137}	Client #4 has an adequate supply of appropriate fitting clothing. There has been some purchases since the last site visit. Please be mindful that client #4 prefers to wear his pants low and will attempt to put them lower on his hips than many of us prefer for him to wear them.	
{W 149}	Surveyor: 19076 483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.	{W 149}		

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{W 149}	Continued From page 4 This STANDARD is not met as evidenced by: Surveyor: 12301 Based on interview and record review, the facility failed to establish and/or implement policies that ensure the health and safety of eight of the eight clients (Clients #1, #2, #3, #4, #5, #6, #7, and #8) included in the sample. The findings include: 1. A follow-up survey was conducted at the facility on March 20, 2007 through March 21, 2007. The review of the unusual incidents that had occurred after March 15, 2007, the date of alleged compliance in the the plan of correction, indicated that the supervisors and the program director had not ensured that each incident was signed within 24 hours of the incident in accordance with the agency's policy. 2. The review of the investigations of unusual incidents/injuries of unknown origin provided to the surveyors on March 20, 2007 revealed the agency failed to provide evidence that the Residential Program Director had been informed of the results of the investigation within five working days of the incident. The review of the revised agency policy on incident management revealed the the Residential Program Director was the designated administrator for the purpose of incident reporting and for reporting the results of the investigtions. According to the Plan of Correction, this policy should have become effective on March 15, 2007.	{W 149}	1. The agency's Policy has been revised to be in alignment with federal and state guidelines and the policies of District's Department of Disability Services (DDS). The agency is following the new policy. 2. The revised policy specified the Residential Program Director as the administrator but this was consistent with what was explained in the initial visits and what was implied in the original policy. The current change is that the staff will actually write on the incident report that (PD) has been notified or an email has been sent (PD is accessible 24/7 via email) to eliminate the confusion about when the PD is first notified. The signature date of the PD's review of the incident report was interpreted as the first date of notification. This will hopefully be clarified by indicating the PD's notification as outlined above. This should be reflected beginning	
{W 153}	483.420(d)(2) STAFF TREATMENT OF CLIENTS	{W 153}		3/22/07

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{W 153}	Continued From page 5 The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Surveyor: 12301 Based on interview and record review, the facility failed to ensure all allegations of mistreatment, abuse, and injuries of unknown origin were immediately reported to the administrator and other officials in accordance with State law. The finding includes: The review of the injuries of unknown origin provided to the surveyors on March 20, 2007 revealed the agency failed to provide evidence that the Residential Program Director had been informed of the incident within 24 hour. Although interview with the Residential Program Director indicated that he was aware of most of the incidents, the documentation on two injuries of unknown origin failed to have a signature of the administrator within 24 hours of the incident. The review of the revised agency policy on incident management revealed the the Residential Program Director was the designated administrator for the purpose of incident reporting and for reporting the results of the investigtions. According to the Plan of Correction, this policy should have become effective on March 15, 2007. 1. Interview with the Program Manager on March	{W 153}	The issue here is that the signature date that the incident report was reviewed as not necessarily the date the administrator is notified. The Program Director is available 24/7 via telephone and email. The staff routinely calls the administrator when incidents occur. However the actual report might not be reviewed until some point after the initial notification. In an effort to reduce the confusion, the supervisory staff has been instructed to list the administrator or designee (Usually a QMRP) in the space denoted as residential provider.	3/22/07

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{W 153}	Continued From page 6 20, 2007 at approximately 11:00AM revealed that the administrator is notified immediately of injuries of unknown origin and client to client mistreatment. Review of an unusual incident report dated February 18, 2007 on March 20, 2007 at approximately 11:30 AM revealed that Client #7 attempted to head butt Client #3. Direct Care Staff #1 intervened and Client #7 than head butted Direct Care Staff #1, on the chest. Direct Care Staff #1 was sent to the hospital emergency room for evaluation and treatment . There was no documented evidence that the administrator and/or other officials had been made aware of the incident until March 2, 2007. 2. Interview with the Program Manager on March 20, 2007 at approximately 11:00AM revealed that the administrator is notified immediately of injuries of unknown origin and client to client mistreatment. Review of an unusual incident report dated February 28, 2007 on March 20, 2007 at approximately 11:45 AM revealed that Client #7 physically assaulted Client # 9 twice with her fists in the left lower intercostal area. There was no documented evidence that the administrator and/or other officials had been made aware of the incident until March 2, 2007.	{W 153}	1. This incident was not interpreted by the provider as an incident of unknown origin or an incident of client to client mistreatment. In this particular case the behaviors exhibited by client #7 are targeted behaviors outlined in a behavior support plan designed specifically for client #7, with specific strategies outlined to address the behavior. The staff person intervened and client #3 never became involved. The administrator was aware of this incident because he was on duty and spoke to the staff shortly after she was evaluated by the nurse. The newly adopted process of indicating that the administrator or designee has been notified under the residential provider line should eliminate the thought that the notification date and the actual review date of the report are the same. 2. See response to W153 (1)	3/22/07
{W 154}	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Surveyor: 12301 Based on interview and record review, the facility failed to ensure allegations of abuse were thoroughly investigated.	{W 154}	According to the Districts Department of Disability Services, these incidents would not qualify for an "investigation" in the sense of an "investigation". The head-butt incident was reviewed as a behavioral issue outlined in an approved behavior support plan. The "team" discussed the situation to determine if extra precautions were necessary to reduce the likelihood of future occurrences.	

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{W 154}	Continued From page 7 The finding includes: The review of unsual incident that were provided during the follow-up survey on March 20, 2007 revealed that a thorough investigation had not been provided for two incidents. These incidents were related to Client #3. On February 16, 2007 Client #3 was head-butted by one of her housemates Client #7. The other incident involved a fall that Client #3 sustained on February 17, 2007.	{W 154}	The fall sustained by client #3 was determined that her shoes were not tied and staff were instructed to ensure all clients' shoes are tied to reduce the probability of future occurrences. This was done in February after the incident occurred.	4/3/07
{W 156}	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Surveyor: 12301 Based on interview and record review, the facility failed to ensure that investigations were reported to the administrator or designated representative with in five working days of the incident. The findings include: The facility failed to have a system for the timely notification of the administrator. The review of the incident investigation provided to the surveyors on March 20, 2007 revealed the agency failed to provide evidence that the Residential Program Director had been informed of the results of incident investigations within five working day of the incidents for five incidents.	{W 156}	The new revised policy and process should reflect more consistently that there is evidence of timely notification and that the results of investigations are within the timeline outlined in the regulations.	4/18/07

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{W 156}	Continued From page 8 Although interview with the Residential Program Director indicated that he signed the investigations, there was no documented evidence the signature took place with the five days for seven incidents that occurred between February 10, 2007 and March 15, 2007 and one incident that occurred after March 15, 2007.	{W 156}		
{W 159}	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Surveyor: 12301 Based on observation, interview and record review the facility failed that each client's active treatment program was coordinated, integrated and monitored by the Qualified Mental Retardation Professional (QMRP). The findings include: 1.Interview with the Residential Program Director on March 21, 2007 indicated that the staff had not been provided the required training on the changes in the agency's incident management policy. The review of the plan of correction indicated that the training on the incident management protocol was scheduled to be provided to the staff on April 15, 2007. During additional discussion with the Residential Program Director, the surveyors informed him that the training on incident management training needed to be completed to allege compliance with the deficiency prior to the next follow-up survey,	{W 159}	1. The staff will receive training on the new incident management policy by: **5/14/07** 2. The staff will begin CPR training by: **4/15/07** All direct care staff will be recertified by: **6/15/07** 3. The first aid training will begin by: **4/30/07** The first aid training will be completed by: **6/15/07** The agency will develop a database to identify the expiration dates of certifications and send reminders to management staff regarding the expiration date of staff members' certifications. **6/30/07**	

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{W 159}	Continued From page 9 2. Cross Refer to W192. The Qualified Mental Retardation Professionals (QMRPs) failed to ensure that all staff received CPR training and had current CPR certifications. 3. The Qualified Mental Retardation Professionals (QMRPs) failed to ensure that all staff received First Aid training and had current First Aid certifications.	{W 159}		
{W 189}	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Surveyor: 12301 Based on observations, interview, and record review, the facility failed to provide each employee with initial and continuing training that enables the employee to perform his or her duties, effectively, efficiently, and competently for two of eight clients included in the sample. (Clients #1 and #4) The findings include: 1. Interview with the Qualified mental Retardation Professional during the follow-up survey on March 20, 2007 revealed that Client #4 did not need to be provided with a feeding protocol, however a plan had been developed to encourage the client to learn good table manners. The review of the plan of correction revealed the training on the meal protocol was scheduled to be	{W 189}	1. The training for the feeding protocol occurred on:	

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{W 189}	Continued From page 10 held by March 20, 2007. 2. Interview with the Residential Program Director on March 21, 2007 indicated that the staff had not been provided the required training on the changes in the agency's incident management policy. The review of the plan of correction indicated that the training on the incident management protocol was scheduled to be provided to the staff on April 15, 2007. During additional discussion with the Residential Program Director, the surveyors informed him that the training on incident management training needed to be completed to allege compliance with the deficiency prior to the next follow-up survey.	{W 189}	2. The training for the supervisors and professional staff occurred on: The incident management policy training will be completed by:	4/27/07 5/15/07
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Surveyor: 19076 Based on staff interview and record review, the facility failed to effectively train staff to implement emergency measures for all of the clients in the facility. The finding includes: Interview with the Compliance Specialist on March 21, 2007 at approximately revealed that staff were scheduled to be trained in CPR. Review of 35 personnel records on March 21, 2007 at approximately 2:00 PM revealed no documented evidence of current CPR training or	W 192	The CPR training is being scheduled no later than: Anticipated date of completion	4/5/07 6/15/07

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W 192	Continued From page 11 CPR certifications for 13 staff members. There was no documented evidence that all direct care staff had CPR training and current CPR certifications.	W 192		
{W 429}	483.470(e)(2)(i) HEATING AND VENTILATION The facility must maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means. This STANDARD is not met as evidenced by: Surveyor: 12301 Based on observation, interview and record review, the facility failed to maintain the temperature within a normal comfort range in the residential facility. The finding includse: Observation of the door and the window in the Rainbow apartment on March 21, 2007 revealed the frames continued to be taped to the edges of the door and window as they were observed by the surveyors to be on February 9, 2007. There was no evidence however that a more permanent solution to prevent the air from coming entering and escaping from the building had been implemented.	{W 429}	The permanent fixes to this problem began: The facilities department caulked the windows and put weather stripping around the doors. This project should be completed by: The process of the spring and fall inspections will be implemented to ensure preparation for season change.	4/9/07 4/30/07
{W 436}	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.	{W 436}		

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{W 436}	Continued From page 12 This STANDARD is not met as evidenced by: Surveyor: 12301 Based on observation, interview and record review, the facility failed to ensure wheelchairs were maintained in good repair for three clients in the survey (Clients #5, #9, and #10; failed to ensure one client (Client #1) was trained to care for his glasses; failed to ensure two clients (Client #2 and #4) was trained to wear their glasses; and failed to ensure adaptive feeding devices were used as approved by the interdisciplinary team for two clients (Clients #5 and #10). The finding includes: The facility failed to ensure that the wheelchairs of Clients #9 and #10 were maintained in good repair. Interview with the Qualified Mental Retardation Professional and the review documents provided during the follow-up survey on March 21, 2007 at approximately 5:15 PM revealed the wheelchairs of Clients #9 and #10 had been assessed for needed repairs and Client #5's wheelchair had been repaired. At the time of the survey however, Clients #9 and #10 were awaiting wheelchair repairs.	{W 436}	Client #1 has been trained to care for his glasses but deliberately breaks them because he does not want to wear them. The QMRP and Psychologist has developed a new strategy to implemented by : Despite the client's deliberate intent to destroy his glasses (so many times Medicaid refuses to buy anymore during this ISP year) the agency is going to purchase one more pair of glasses to try and implement the new strategy Client's #2 and #4 do not need glasses according to their most recent assessments (see assessment) the adaptive feeding device have been obtained and the spare devices are available to be seen at upcoming cite visit by: The wheelchair for client #5 has been repaired (See attachment) The repair for client #9's chair was started on And is anticipated to be completed by: The repair to client #10's chair is scheduled to be done on : at the client's school.	5/10/07 5/10/07 5/10/07 4/23/07 5/4/07 4/30/07

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G002	A. BUILDING _____ B. WING _____	R 03/21/2007

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{I 000}	INITIAL COMMENTS A follow-up licensure survey was conducted on March 21, 2007. A random sampling of eight clients was selected from a population of twenty-nine (29) residents with various disabilities. The findings were based on observations, interviews with clients, facility staff, school and day program staff, as well as the review of client habilitation and administrative records, including incident reports.	{I 000}		
I 081	3503.9 BEDROOMS AND BATHROOMS Each bathroom shall be equipped to facilitate training toward maximum self-help by residents including individuals with physical disabilities and shall have appliances, fixtures or devices which shall be appropriate to the needs of each person who lives and works in the This Statute is not met as evidenced by: The finding includes: Room 109 The hot water control were observed to be installed on the right side of the handsink in the bathroom. The cold water control was installed on the left side of the handsink. There was no evidence the water controls at the handsink in the bathroom were installed in a manner to facilitate maximum self-help by the residents.	I 081	The hot water control was corrected by: The hot water is on the left and the cold water is on the right.	4/17/07
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of	I 090		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ruben N. Harper Jr. TITLE: Program Manager (X6) DATE: 4/27/07

Health Regulation Administration

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I 090	Continued From page 1 accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: The findings include: The following environmental concerns were identified during the inspection on March 21, 2007. 1. Room 113 a. Bed drawer on left side of the room was observed to be off the tract causing it to be difficult to close. b. The handrail in the shower of the bathroom was not tightly secured to the wall. 2. A trash can was observed in the hallway which lacked a lid. 3. Room 112 a. The left door of the storage unit underneath the bed was observed to be broken. b. Multiple cracks were observed in the vinyl covering of the green couch in the living room. C. The window was observed to be taped to the frame of the window. 4. Room 110 a. A semi-circular open area was observed at the bottom of the door leading to the exterior of the building from the living room. b. Multiple cracked areas were observed on the couch of the living room.	I 090	1. Room 113 a. The drawer on the bed will be repaired by: b. The handrail in the shower will be repaired by: 2. A lid for the trash can will be obtained by: or a trash can will be obtained by: 3. Room 112 a. The left door for storage under the bed will be repaired by b. A cover will be obtained for the couch by: c. The tape on the windows has been done around the windows. 4. Room 110 a. The area at the bottom of the door has been straightened. If it remains a problem and the bottom does not fit properly, the door will be replaced prior to b. A cover for the couch will be obtained by:	4/30/07 4/30/07 4/15/07 4/30/07 4/30/07 4/30/07 4/9/07 4/27/07 7/1/06 4/30/07

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I 090	Continued From page 2 C. The caulking at the back of the second bathroom sink was observed to be separating from the wall. d. The blinds in the bedroom were observed to be missing several louvers. e. The belt on the shower chair in the first bathroom was observed to be heavily stained at the back of the chair. Room 109 a. A tear approximately 12 inches long was observed in the back of the couch in the living room. b. An unpleasant odor was detected in the bedroom. c. The blinds in the living room had several missing louvers. d. The hot water controls were observed to be installed on the right side of the handsink. The cold water control was installed on the left side of the handsink. There was no evidence the were installed in a manner to increase the activity of daily living skills of the residents. Room 108 a. The bottom edges of the drawers of the storage chest. b. A torn area was observed on the pillow of the couch. Room 106 a. Two broken drawers were observed on the the empty bed . b. No blinds, curtains or other covering was	I 090	c. The sink was re-caulked on: d. The blinds will be replaced by: e. The belt on the chair is discolored but it is clean. The discoloration is from use but the chair and the fabric is still good. The staff will try to use some whitener on the straps but it is expensive equipment with "use" still left in it Room 109 a. A cover for the sofa will be obtained by: b. The staff will try and coax the client to allow housekeeping to assist him with cleaning his area by: c. Blinds will be replaced by: d. The hot water controls were corrected by: Room 108 a. The bottom edges of the drawer were sanded by: b. A cover will be obtained for the couch by: Room 106 a. The drawers on the empty bed will be obtained for the window by: b. Blinds will be obtained for the window by:	4/17/07 4/30/07 4/30/07 4/30/07 4/28/07 4/30/07 4/17/07 4/18/07 4/30/07 4/30/07 4/30/07

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I 090	Continued From page 3 observed at the window beside the window. Room 102 a. Several louvers were observed to be missing from the window blinds in the bedroom. Laundry room a. A heavy accumulation of dust was observed at the sides of the sides and behind the washer and dryer. Dining room a. Two of three trash cans in the dinig room were observed to be without lids. Room 107 a. Caulking on the bathtub was cracked.	I 090	Room 102 a. Blinds will be repaired by: Laundry Room a. Laundry room was cleaned on: Dining Room: a. Lids on new trash cans will be obtained by: Room 107 a. The tub was caulked:	4/30/07 4/27/07 4/30/07 4/19/07
{I 091}	3504.2 HOUSEKEEPING Housekeeping and maintenance equipment shall be well constructed, properly maintained and appropriate to the function for which it is to be used. This Statute is not met as evidenced by: Based on observation interview and record, the GHMRP facility failed to ensure the temperature in various areas of the building was maintained within a normal comfort zone. The findings include: See Federal Deficiency Report - Citation W429.	{I 091}		
I 108	3504.15 HOUSEKEEPING Each GHMRP shall assure that each resident has	I 108		

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I 108	Continued From page 4 at least seven (7) changes of clothing appropriate to his or her daily activities. This Statute is not met as evidenced by: The findings include: Observations in the the clothing supply on March 21, 2007 revealed several of the residents lacked a seven day supply of socks. Interview with the Residential Program Director and the Qualified Mental Retardation Professional indicated some of the residents' clothing were in the laundry room. Inspection of the clean socks in the laundry room revealed the additional socks could not be located because they were not labeled. There was no evidence that each resident was provided with seven changes of socks.	I 108	The socks in the laundry room wore labeled and every child has 7 pairs of socks. This will be reaffirmed on : If any were lost purchases will be made by:	4/27/07 4/30/07
I 109	3504.16 HOUSEKEEPING Each GHMRP shall label inconspicuously each item of clothing as belonging to a particular resident as indicated in his or her Individual Habilitation Plan (IHP). This Statute is not met as evidenced by: The finding includes: Observations in the laundry room on March 21, 2007 revealed a large pile of clean socks on top of the dryer. Further observation of the socks revealed more that half of the sock had no name of initials on them. Interview of the staff indicated it could not be determined specifically who the owners of the unidentified socks were.	I 109	See response to I 108 3504-15	

Health Regulation Administration

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I 111	Continued From page 5	I 111		
I 111	3504.18 HOUSEKEEPING Each GHMRP shall establish sorting and washing procedures to ensure adequate sanitation either by assisting the residents to perform these tasks or by performing the tasks for the residents as indicated in the their Individual Habilitation Plan (IHP). This Statute is not met as evidenced by: The findings include: Observations in the living units on March 21, 2007 revealed an insufficient number of hampers were available for the storage of the residents' soiled clothing in the following living areas: a. Room 103: two hampers for three residents b. Room 102: two hampers for three residents c. Room 100: one hamper for two residents	I 111	a. Hampers will be obtained: So that each individual had their own hamper. b. Hampers will be obtained so that each person has their own. This will be done by: c. Hampers will be obtained so that each person has their own	4/30/07 4/30/07 4/30/07
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on record review, the facility failed to have current health certifications on file for all staff.	I 206	The staff surveyed were notified and requested to provide proof of a physical. The staff will submit health certificates by: Or at least proof that one has been scheduled. In the future the program is using this survey to develop a database that expiration dates of health certificates can be flagged. The database will be developed by:	5/7/07 6/1/07

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I 206	Continued From page 6 The findings include: Review of 35 personnel records on March 21, 2007 at approximately 2:40 PM revealed no documented evidence of current health certifications for 12 staff members. Note: Staff ([redacted] and [redacted].)	I 206		
I 224	3510.5(a) STAFF TRAINING Each training program shall include, but not be limited to, the following: (a) Overview of mental retardation including, but not limited to, definition, causes of mental retardation, associated health implications, and frequently used medications, the history of care of individuals with mental retardation, and daily living skills; This Statute is not met as evidenced by: The findings include: The facility failed to ensure that staff were effectively trained on the maintenance of dental hygiene. Observation of the hygiene kits of Residents in room 112, room 111, room #103, room 108, room 106 and revealed the tooth brushes were worn. Several of the worn tooth brushes were replaced with new tooth brushes during the inspection. There was no evidence that each staff was trained on the importance of maintaining tooth brushes in good condition to encourage to promote more thorough cleaning of the resident's teeth and gums. The battery operated tooth brushes of the	I 224	a. These topics are covered in the Programs orientation. A systematic training calendar will be developed and implemented by : To ensure that these topics are reiterated at times other than at the orientations. The Program's nursing staff has identified oral hygiene concerns and ha provided training as evidenced by signature sheets dated 7/11/06, 9/20/06, 9/24/06, and 2/6/07. The program will continue to provide training and encourage the direct care staff to support the individuals as outlined in the training. This process will continue and through the newly developed database the agency will ensure that it is routinely covered.	6/15/07 6/15/07

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I 224	Continued From page 7 residents of room 102 were observed to stored uncovered in the personal kits. There was no evidence staff was effectively trained on the importance of covering the tooth brushes to prevent possible contamination from other items in the personal storage kits.	I 224	All tooth brushes will be in good repair and have covers by: The QMRPs and Supervisors will provide routine training and check the condition of the brushes.	4/30/07
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on record review, the facility failed to effectively train staff to implement emergency measures for all of the clients in the facility. The findings include: 1. Review of 35 personnel records on March 21, 2007 at approximately 2:00 PM revealed no documented evidence of current CPR/ (Heimlich Maneuver) certifications for 13 staff members. Note: Staff ([redacted]) 2. Review of 35 personnel records on March 21, 2007 at approximately 2:30 PM revealed no documented evidence of current First Aid certifications for 14 staff members. Note: Staff ([redacted])	I 227	c. The program will develop a training to ensure that the routine areas are done in a systematic way. The development will commence immediately but will not be completed until (personnel change): 1. The trainings for CPR has been scheduled and is being done regularly as of: This too will be flagged in the newly developed tracking system (database). 2. The first aid certification dates will also be included in the database so that the expirations can be flagged.	7/1/07 4/5/07

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{I 379}	Continued From page 8	{I 379}		
{I 379}	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the Department of Health, Health Facilities Division was notified of unusual incidents that substantially interfered with a resident ' s health. The finding includes: See Federal Deficiency Report - Citation W153.	{I 379}	See response to federal deficiency report for W 153	
{I 401}	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the provision of professional services.	{I 401}		

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{I 401}	Continued From page 9 The findings include: 1. Review of the Plan of Correction (POC) on March 20, 2007 at approximately 11:00AM revealed that Client #7 was to have an occupational therapy(OT) assessment to determine her ability to use a fork or knife during mealtime. Further review revealed that the OT assessment would be conducted by March 21, 2007. Interview with the Assistant Program Manager on March 21, 2007 at approximately 4:25PM revealed that Client #7's OT assessment had to be rescheduled for a later date. There was no evidence that an OT assessment had been completed for Client #7. [See also Federal Deficiency Report-W120] 2. The facility failed to ensure that the wheelchairs of Clients #9 and #10 were maintained in good repair. Interview with the Qualified Mental Retardation Professional and the review documents provided during the follow-up survey on March 21, 2007 at approximately 5:15 PM revealed the wheelchairs of Clients #9 and #10 had been assessed for needed repairs and Client #5's wheelchair had been repaired. At the time of the survey however, Clients #9 and #10 were awaiting wheelchair repairs. [See Federal Deficiency Report - W436] W120, W159,	{I 401}	1. The assessment had been scheduled and there was a miscommunication and the individual had already completed her meal by the time the Occupational Therapist arrived. The therapist understood the urgency of the matter and arranged to observe her at lunch on : (See assessment and response to federal report W 120) 2. The access to a variety of vendors who repair adaptive equipment is limited and sometimes the wait for bureaucratic approvals delay timely notifications that a repair is needed. Client #5's chair was repaired on : Client #9's chair was partially repaired on : And is scheduled to be completed by: Client #10's chair is scheduled to be repaired at his school on:	3/21/07 3/1/07 4/23/07 5/4/07 4/30/07
{I 500}	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and	{I 500}		

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{I 500}	Continued From page 10 protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the protections of each clients rights. The findings include: See Federal Deficiency Report - Citations W125, W137, W149, W153, W154, W156, and W264.	{I 500}	See response to W125, W137, W149, W153, W154, W156, and W264)	